

**TO BE COMPLETED BY THE RESPONDENT**

An application has been made pursuant to the *Mandatory Blood Testing Act, 2006* in which you are named as respondent. In the application, the applicant alleges that he or she came into contact with your bodily substance and wishes to have your blood analysed for HIV/AIDs, Hepatitis B or Hepatitis C. Details of the occurrence as described in the physician and applicant reports are available from the medical officer of health.

If you do not agree to provide a blood sample voluntarily, the application will be referred to the Consent and Capacity Board and an order may be made by the Board requiring you to allow a physician, medical laboratory technologist or registered nurse (with an extended certificate of registration under the *Nursing Act, 1991*) to take a blood sample for analysis for HIV/AIDs, Hepatitis B or Hepatitis C in accordance with the *Mandatory Blood Testing Act, 2006*.

Collection, use and disclosure of the personal information on this form is for the consideration of an application under the *Mandatory Blood Testing Act, 2006* for an order requiring a respondent to give a blood sample to determine the HIV/AIDs, hepatitis B and/or hepatitis C status of the respondent. The authority for collection and use of this information is the *Mandatory Blood Testing Act, 2006*. For information about collection practices contact the Corrections and Community Safety Policy Branch, Ministry of Community Safety and Correctional Services at 416-325-7331.

**YOU HAVE THE RIGHT TO BE PRESENT AT A HEARING, IF THERE IS ONE, WHETHER OR NOT YOU SUBMIT THIS FORM TO THE CONSENT AND CAPACITY BOARD. IF YOU DO NOT COMPLETE THIS FORM AND SUBMIT IT TO THE CONSENT AND CAPACITY BOARD, THE APPLICATION MAY BE CONSIDERED WITHOUT REGARD TO THE INFORMATION CONTAINED IN THIS FORM.**

**THIS FORM IS NOT INTENDED TO REPLACE YOUR PRESENCE AT THE HEARING.**

**Keep one copy of this form and send one copy by FAX to the Consent and Capacity Board  
Fax Number: 416-327-4207 or 1-866-777-7273**

**A. Respondent Information**
**Name**

Last Name	First Name	Middle Name
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**Address**

Unit Number	Street Number	Street Name			
City/Town	Province Ontario	Postal Code	Home Telephone ( )	Business Telephone ( )	
OHIP Number (10 digits)		Version	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth (yyyy/mm/dd)

**Family Physician**

Last Name	First Name	Middle Initial			
Unit Number	Street Number	Street Name			
City/Town	Province Ontario	Postal Code	Office Telephone ( )	Office Fax Number ( )	

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Have you been approached to voluntarily provide information respecting whether you are positive for HIV/AIDS, Hepatitis B and Hepatitis C or to voluntarily provide a blood sample to be tested for these diseases?

No  Yes, *explain*

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If you answered "No" to the previous question, would you agree to voluntarily provide information respecting whether you are positive for HIV/AIDS, Hepatitis B and Hepatitis C or to voluntarily provide a blood sample to be tested for these diseases?

No  Yes

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If an order is made to provide a blood sample, do you want your family physician named on the order?

No  Yes

Do you want the report on the results of the blood analysis to be delivered to your physician?

No  Yes

## B. Details of Occurrence

In the application, the applicant claims that he or she came into contact with your bodily substance.

Do you recall the circumstances where the applicant may have come into contact with your bodily substance? *Explain.*

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Do you recall the date, time and location where the applicant may have come into contact with your bodily substance?

Date (yyyy/mm/dd)	Time	Unit Number	Street Number	Street Name
	<input type="checkbox"/> am <input type="checkbox"/> pm			

City/Town

Province  
Ontario

Postal Code

**C. Blood Sample Information – Explain any circumstances that might put your health or life in danger if a blood sample is taken from you.**

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**D. Additional Information - Provide any other information you believe may be relevant to the application, including mental anguish, stress or anxiety.**

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**E. Information Accurate**

I hereby confirm that the information provided in this form is accurate to the best of my knowledge.

**Name of Respondent - please print**

Last Name

First Name

Middle Initial

Signature

Date (yyyy/mm/dd)